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Office of Administrative Law Judges
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Issue date: 02Aug2001

CASE No.: 2000-BLA-00104

In the Matter of:

JOSEPH S. BRIDI
Claimant

v.

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party-In –Interest

Appearances:

Helen M. Koschoff, Esquire
For the Claimant

Timothy S. Williams, Esquire
For the Director

Before: Ainsworth H. Brown
Administrative Law Judge

DECISION AND ORDER ON MODIFICATION DENYING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901 et seq (the Act). The Act provides benefits to persons totally disabled due to pneumoconiosis and to certain survivors of persons who had pneumoconiosis and were totally disabled at the time of their death or whose death was caused by pneumoconiosis. Pneumoconiosis is a chronic dust disease of the lungs, including respiratory and pulmonary impairments arising out of coal mine employment, and is commonly referred to as black lung.

On November 3, 1999, the Director, Office of Workers' Compensation Programs, referred this case to the Office of Administrative Law Judges for a formal hearing. A hearing was held before me in Reading, Pennsylvania on June 26, 2000, at which time all parties were

given a full opportunity to present evidence [1] and argument as provided in the Act and the Regulations issued thereunder, found at Title 20, Code of Federal Regulations. [2] Director was allowed additional time to submit evidence. TR 10. Claimant was allowed additional time to proffer rebuttal evidence. [3] TR 15. On February 15, 2001, Director filed a post-hearing brief.

ISSUES

The contested issues [4] are:

(1) The length of Claimant's coal mine employment;
(2) Whether Claimant has pneumoconiosis;
(3) Whether Claimant's pneumoconiosis arose out of coal mine employment;
(4) Whether Claimant suffers from a totally disabling pulmonary or respiratory impairment;
(5) Whether Claimant's total disability is due to pneumoconiosis;
(6) whether Claimant has established either a mistake in determination of fact or a change in condition; and
(7) whether reopening this claim on modification would render justice under the Act.

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[1] The following references will be used herein: TR for transcript, CX for Claimant's exhibit, DX for Director's exhibit.

[2] At the hearing Director's exhibits 1 through 86 and Claimant's exhibits 1 through 16 were admitted into evidence without objection. TR 5, 7, 19. Post-hearing, Claimant submitted CX-17, a medical report from Dr. Matthew Kraynak dated 9-5-00. Director submitted additional exhibits DX-87 through DX-91.

[3] Subsequent to the hearing, there was a conflict between the parties as to the scheduling of the deposition of Dr. Cander. Claimant requested said deposition for purposes of cross-examination. Because Dr. Cander was unable to testify at a deposition, on December 7, 2000, I issued an Order directing Dr. Cander to answer questions by way of Interrogatories and that the breathing study, arterial blood gas study and chest x-ray of July 13, 2000 be turned over to Claimant for review. The record was left open until January 26, 2001 for submission of additional evidence by Claimant followed by a 20-day period to submit closing briefs. Following said Order, I have not received any additional submissions from Claimant. Claimant did not file a closing brief. The record is now closed. Based on the foregoing, I am denying Claimant's earlier request to strike the medical reports of Drs. Cander and Galgon. Claimant has had ample opportunity to submit additional rebuttal evidence but has failed to do so without explanation.

[4] Prior to the hearing, Claimant filed a Motion to Strike the Director's opposition to the issues of existence of the disease and causal relationship because Judge Teitler in his Decision had found Claimant had established said issues. On May 3, 2000, I issued an Order denying Claimant's Motion to Strike as there had not been a full litigation in this matter on those issues, i.e. a decision on the merits by the Benefits Review Board.

For the reasons stated herein, I find that Claimant has failed to establish entitlement to benefits on modification.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Background and Procedural History

Joseph S. Bridi, Claimant, was born on February 14, 1942. DX-1. He is married to his wife, Anne Marie. TR 24-25. He has no other dependents for purposes of augmentation of benefits under the Act. TR 24-25.

While this case was pending a decision, new Federal Regulations were promulgated. Subsequently, there was litigation contesting their liability. On February 23, 2001, I issued an Order requiring the parties to submit a brief regarding the issue of whether specific regulations, i.e. 20 C.F.R. §§718.104(d), 718.201(a)(2). 718.201(c), 718.204(a), 718.205(c)(5) and 718.205(d), would affect the outcome of the current litigation. On March 2, 2001, Director submitted a response indicating that the new regulations would not affect the outcome of this case. Claimant did not file a response. Said failure will be construed as a position that the amended regulatory provisions will not affect the outcome of the claim. As all parties are in agreement, I concur and find that the amended regulations will not affect the outcome of the current litigation.

Claimant filed his claim for benefits on August 29, 1995 DX-1.[5] The claim was denied by the District Director on November 29, 1995. Dx-14. Claimant appealed and a formal hearing was held before Administrative Law Judge ("ALJ") Paul Teitler on October 24, 1996. DX-68. In a Decision and Order Denying Benefits issued on November 8, 1997, Judge Teitler credited Claimant with five (5) years of coal mine employment and found Claimant had established the existence of pneumoconiosis and causal relationship but also found Claimant had failed to establish total disability. DX-73. Claimant appealed to the Benefits Review Board ("BRB"). The BRB subsequently dismissed the appeal as abandoned. Claimant requested Modification of his claim on July 8, 1999. Claimant's request was denied by the District Director on August 30, 1999. DX-80. The case was referred to the Office of Administrative Law Judges and on June 26, 2000 a formal hearing was conducted in Reading, Pennsylvania.

Claimant testified that his breathing had become worse since his last hearing. TR 25. He

[5] Given the filing date of this claim, subsequent to the effective date of the permanent criteria of Part 718, (i.e. March 31, 1980), the regulations set forth at 20 C.F.R. Part 718 will govern its adjudication. Because Claimant's last exposure to coal mine dust occurred in the Commonwealth of Pennsylvania this claim arises within the territorial jurisdiction of the United States Court of Appeals for the Third Circuit. *See Broyles v. Director, OWCP*, 143 F.3d 1348, 21 BLR 2-369 (10th Cir. 1998).

was never a smoker. TR 25. Claimant stated he did not have a heart problem. TR 25. He stated he could only walk about 200 feet before needing a break and that he needed to stop and rest after climbing ten (10) steps. TR 26. Claimant stated he continued to treat with Dr. Raymond Kraynak for his breathing problems. He had been with Dr. Kraynak for more than four (4) years. TR 26-27. Claimant testified he was on two breathing medications: Proventil and Ventolin. TR 27. He noted his cough worsens in hot, humid weather and that air conditioning helps. TR 27. He concluded that he could not perform his coal mine employment due to his breathing problems. TR 28. On cross-examination, Claimant noted he had worked for the Ford Motor Company from 1966 through 1995 as a mechanic. TR 28. In that position he used a milling machine, lathe and a drill. He maintained that the equipment was equipped with ventilation systems. TR 29-30. He stopped working in 1995 due to his breathing but admitted that he retired with a pension and had thirty (30) years with Ford. (TR 31-32).

Length of Coal Mine Employment

Neither the Act nor the Regulations contain guidelines for computing the length of coal mine employment. The Benefits Review Board has held that such computations should be based on some reasonable method with the result supported by substantial evidence in the record considered as a whole. *Wilkerson v. Georgia Pacific Corp.*, 1 BLR 1-830 (1978). The Board has also held that the finding must be made with exactness. *Lauderback v. Director, OWCP*, 1 BLR 1-1033 (1978); *Gibson v. Director, OWCP*, 1 BLR 1-1016 (1978). The burden of proof is upon the claimant. *Rennie v. U.S. Steel Corp.*, 1 BLR 1-859 (1978).

Claimant alleged fifteen (15) years of coal mine employment. Director conceded 2.75 years, and Judge Teitler, in his Decision and Order, credited Claimant with five (5) years of coal mine employment. Claimant did not submit any additional evidence regarding this issue but maintained that Judge Teitler made a mistake in fact in evaluating the evidence of record. I agree.

Claimant testified that he picked, cracked, and screened coal from the age of eight (8) to the age of sixteen (16), after school (two hours per day, DX-68, page 8), on weekends (four hours per day, DX-68, page 8), and during summer vacations (seven hour per day, DX-68, page 9) from 1950 to 1958. DX-2. Claimant testified that he regularly worked as a miner for various coal companies from 1958 to 1963. He was a self-employed miner from 1963 through 1966, when he began a thirty (30) year career at Ford Motor Company.

With regard to Claimant's work from 1950 to 1958, the regulations require that Claimant receive credit for a full day even for any part of a day spent working at a mine. 20 C.F.R. §725.101(a)(32). I find Claimant's testimony regarding this period of employment to be credible. Accordingly, I will credit Claimant with eight (8) years of coal mine employment from this period.

With regard to Claimant's work from 1958 to 1966, I find Claimant's testimony was not consistent with the social security records. Nor was it consistent with Claimant's application for benefits or the History of Coal Mine Employment Form he completed. An ALJ may assign determinative weight to social security records upon a finding that claimant's testimony is inconsistent and unsubstantiated. *Miller v. Director, OWCP*, 7 BLR 1-693 (1985). The social security records reflected three (3) years in which Claimant worked at least one hundred and twenty five (125) days: 1963, 1964, and 1965. Accordingly, I will credit Claimant with an additional three (3) years of coal mine employment for this period for a total of eleven (11) years of coal mine employment.

Standard for Modification

Section 22 of the Longshore and Harbor Workers' Compensation Act provides in part that

Upon his own initiative, or upon the application of any party … on the ground of a change in conditions or because of a mistake in a determination of fact … the [fact-finder] may, at any time … prior to one year after the rejection of a claim, review a compensation case …

33 U.S.C. §922, as incorporated by 30 U.S.C. §932(a) and implemented by 20 C.F.R. §725.310.

Section 22 provides the sole avenue for changing otherwise final decisions on a claim. *Metropolitan Stevedore Co. v. Rambo*, 515 U.S. 291, 295 (1995)(*Rambo I*); *Kinlaw v. Stevens Shipping and Terminal Co.*, 33 BRBS 68 (1999), *aff'd*., No. 99-1954, 2000 U.S.App. LEXIS 31354 (4th Cir. April 5, 2000).

Judicial authority requires a broad reading of Section 22, and neither the wording of the statute nor its legislative history supports a "narrowly technical and impractical construction." *O'Keefe v. Aerojet-General Shipyards, Inc.*, 404 U.S. 254, 255 (1971); *Branham v. Beth Energy Mines, Inc.*, 20 BLR 1-27, 1-31-33 (1996). Given its liberal application, it is clear that the petition seeking modification need not allege any specific ground or relief. *See Keating v. Director, OWCP*, 71 F.3d 1118, 1123, 20 BLR 2-53 (3d Cir. 1995); *Jessee v. Director, OWCP*, 5 F.3d 723, 18 BLR 2-26 (4th Cir. 1993); *accord Consolidation Coal Co. v. Worrell*, 27 F.3d 227, 18 BLR 2-290 (6th Cir. 1994); *see generally Fireman's Fund Insurance Co. v. Bergeron*, 493 F.2d 545, 547 (5th Cir. 1974); H.Rep.No. 1244, 73d Cong., 2d Sess. 4 (1934).

While the modification procedure, and the adjudicator's authority to reopen the claim, is "easily invoked," *Betty B Coal Co. v. Director, OWCP*, 194 F.3d 491, 497, 22 BLR 2-1 (4th Cir. 1999) (*Stanley*), the decision whether to grant modification on the basis of a mistake in determination of fact is committed to the adjudicator's discretion. *See Kinlaw*, 2000 U.S.App. LEXIS 31354 at *8-10, *aff'g* 33 BRBS 68 (1999); *see also Duran v. Interport*

Maintenance Co., 27 BRBS 8,14 (1993) (Board reviews Section 22 findings under abuse of discretion standard).

The adjudicator must examine the record as a whole, *see Keating*, 71 F.3d at 1123, 20 BLR 2-53, render findings which must be supported by substantial evidence, and articulate a rationale for its decision, even though the decision on whether to reopen a claim is committed to its discretion. Indeed, the adjudicator "has the authority, *if not the duty*, to reconsider all the evidence for any mistake of fact or change in condition," *Worrell*, 27 F.3d at 230, 18 BLR 2-290 (emphasis added); *see Jessee*, 5 F.3d at 726, 18 BLR 2-26 (deputy commissioner "must" review request for modification), by examining "wholly new evidence, cumulative evidence, or merely [by] further reflection on the evidence initially submitted." Moreover, if the evidence establishes that a claimant's condition has worsened, modification will be appropriate because a claimant "should receive his benefits if and when he becomes entitled to them." *Stanley*, 194 F.3d at 500 n.4, 22 BLR 2-1.

In every instance, the party who seeks to reopen a claim on modification bears the burden of proof. *Metropolitan Stevedore Co. v. Rambo*, 521 U.S. 121, 138-39 (1997) (*Rambo II*); *Greenwich Collieries v. Director, OWCP*, 990 F.2d 730, 736, 17 BLR 2-64 (3d Cir. 1993), *aff'd* 512 U.S. 267 (1994).

With this in mind, I turn to the merits of Claimant's Request for Modification. While this decision is based on a *de novo* review and consideration of the administrative record as a whole, not all of the evidence that has been introduced prior to the instant request for modification, and has been set forth in the prior Decisions, may again be listed except as required for an analysis of the current request for modification. *See generally Wheeler v. Apfel*, 224 F.3d 891, 895 n.3 (8th Cir. 2000).

Further, given the progressive nature of pneumoconiosis, *see Eastern Associated Coal Corporation v. Director, OWCP*, 220 F.3d 250, 258 (4th Cir. 2000), the more recent evidence with respect to the nature and extent of Claimant's pulmonary or respiratory disability would be the more probative of his condition at the time of the hearing. *See Cooley v. Island Creek Coal Co.*, 845 F.2d 622, 11 BLR 2-147 (6th Cir. 1988); *see also Wetzel v. Director, OWCP*, 8 BLR 1-139 (1985).

Entitlement to Benefits: In General

Entitlement to benefits depends upon proof of three elements: in general, a miner must prove that: 1) he has pneumoconiosis which 2) arose out of his coal mine employment and 3) is totally disabling. Failure to prove any of these requisite elements precludes a finding of entitlement. *Perry v. Director, OWCP*, 9 BLR 1-1 (1986)(en banc). Because Claimant has previously failed to establish with finality any of the foregoing elements, I must review

the record as a whole to determine whether he has proven that he has pneumoconiosis, 20 C.F.R. §718.202, which arose out of his coal mine employment, 20 C.F.R. §718.203, that he is totally disabled, 20 C.F.R. §718.204(c); *see Carson v. Westmoreland Coal Company*, 19 BLR 1-16 (1994), *modified on recon.* 20 BLR 1-64 (1996); *see also Beatty v. Danri Corp.*, 49 F.3d 993, 19 BLR 2-136 (3d Cir. 1995), and whether pneumoconiosis is a substantial contributor to any total pulmonary or respiratory disability. 20 C.F.R. §718.204(b); *Bonessa v. U.S. Steel Corp.*, 884 F.2d 726, 13 BLR 2-23 (3d Cir. 1989).

Entitlement:: Determination of Pneumoconiosis

Claimant must first establish the presence of pneumoconiosis. Pursuant to §718.202, a living miner can demonstrate pneumoconiosis by means of: (1) x-rays interpreted as being positive for the disease; or (2) biopsy evidence; or (3) the presumptions described in Sections 718.304, 718.305, or 718.306, if found to be applicable; or (4) a reasoned medical opinion which concludes presence of the disease, if the opinion is based on objective medical evidence such as blood-gas studies, pulmonary function studies, physical exams, and medical and work histories.

The Third Circuit, under whose jurisdiction this case arose, held that all of the relevant evidence relating to pneumoconiosis under §§718.202(a)(1-4) must then be weighed together to determine whether the claimant has established the existence of pneumoconiosis by a preponderance of the evidence. *Penn Allegheny Coal Co. v. Williams*, 114 F.3d 22, 24-25, 21 B.L.R. 2-104 (3rd Cir. 1997).

a. Chest X-ray Evidence

Chest x-ray interpretations were submitted into evidence which are relevant to the determination of whether Claimant has pneumoconiosis. The following is a listing of the admissible x-ray readings, together with the names and qualifications of the interpreting physicians [6]:

Date	Exhibit	Doctor	Rereading	Qual	Conclusion
9-14-95	DX-11,12	Conrad, BCR	9-14-95	1	No CWP
9-14-95	DX-13	Sargent, BCR,B	10-2-95	3	0/0

[6] The symbol “BCR” denotes a physician who has been certified in radiology or diagnostic roentgenology by the American Board of Radiology, Inc., or the American Osteopathic Association. The symbol “B” denotes a physician who was an approved “B-reader” at the time of the x-ray reading. A B-reader is a radiologist who has demonstrated his expertise in assessing and classifying x-ray evidence of pneumoconiosis. These physicians have been approved as proficient readers by the National Institute of Occupational Safety & Health, U.S. Public Health Service pursuant to 42 C.F.R. §37.51 (1982).

9-14-95	DX-39	Mathur, BCR,B	4-25-96	1	1/1
9-14-95	DX-41,60	Marshall, BCR,B	5-9-96	3	1/0
9-14-95	DX-43	Smith, BCR,B	5-16-96	1	1/0
9-14-95	DX-45	Bassali, BCR,B	6-3-96	2	1/1
9-14-95	DX-49	Brandon, BCR,B	6-25-96	2	1/1
9-14-95	DX-19	Francke, BCR,B	7-29-96	1	0/0
9-14-95	DX-21	Lippman, B	8-12-96	Unreadable, neg.	
9-14-95	DX-23	Navani, BCR,B	8-24-96	2	no CWP
9-14-95	DX-32	Gaziano, B	9-8-96	2	negative
9-14-95	CX-9	Cappiello, BCR,B	4-21-00	2	1/1,scattered small rounded op.
9-14-95	CX-5	Miller, BCR,B	4-26-00	2	1/1, multiple opacities
7-1-96	DX-33	Gaziano, B	9-8-96	1	no CWP
7-1-96	DX-37	Ranavaya, B	9-19-96	2	0/1
7-1-96	DX-59	Mathur, BCR,B	10-16-96	1	1/1
7-1-96	DX-61	Smith, BCR,B	10-22-96	1	1/0
7-1-96	CX-10	Cappiello, BCR,B	4-21-00	2	1/1, scattered small op.
7-1-96	CX-6	Miller, BCR,B	4-26-00	2	1/1, multiple opacities
5-4-00	DX-90	Navani, BCR,B	8-31-00	2	no CWP
5-8-00	CX-13	Miller, BCR,B	6-5-00	2	1/0, multiple opacities
5-8-00	CX-14	Cappiello, BCR,B	6-5-00	1	1/1, scattered small op.
7-13-00	DX-88	Galgon, B	7-13-00	1	0/1, q/p
7-13-00	DX-89	Navani, BCR,B	8-31-00	1	no CWP

Where two or more x-ray reports are in conflict, the radiologic qualifications of the physicians interpreting the x-rays must be considered. §718.202(a)(1). The interpretations of dually qualified physicians are entitled to more weight that the interpretations of B-readers. *Herald v. Director, OWCP*, BRB No. 94-2354 BLA (Mar. 23, 1995)(*unpublished*).

Overall, there are twenty-five (25) interpretations of five (5) x-rays in the record. Of the twenty-five (25) interpretations, eleven (11) were negative and thirteen (13) were positive for pneumoconiosis. There are five (5) negative interpretations that have been rendered

by Board-Certified Radiologists and B-readers. All thirteen (13) positive interpretations were rendered by dually qualified physicians. However, an administrative law judge is not required to simply defer to a bare "numerical superiority" of x-rays. *Wilt v. Wolverine Mining Co.*, 14 BLR 1-70 (1990).

It is proper to accord more weight to the more recent x-ray films of record. *Clark v. Karst-Robbins Coal Co.*, 12 BLR 1-49 (1989) (en banc).

The record contains one (1) negative interpretation of the recent x-ray of 5-4-00, two (2) positive interpretations of the recent x-ray of 5-8-00, and two (2) negative interpretations of the most recent x-ray of 7-13-00. Of the five (5) interpretations, there are two (2) positive interpretations by dually qualified physicians and two (2) negative interpretations by dually qualified physicians.

I accord more weight to the interpretations of the dually qualified Board-certified radiologists and B-readers. However, the most recent x-ray evidence is evenly divided between Claimant and Director (i.e. 2 positive interpretations and 2 negative interpretations by dually qualified physicians). In *Director, OWCP v. Greenwich Collieries*, 114 S.Ct. 2251 (1994), *aff'g. sub. nom., Greenwich Collieries v. Director, OWCP*, 990 F.2d 730 (3d Cir. 1993), the United States Supreme Court dispensed with the "true doubt" rule thereby requiring claimants to establish the requisite elements of entitlement by a preponderance of the evidence. Accordingly, since the most recent evidence is evenly divided between the Claimant and Director, I find that Claimant has failed to prove by the preponderance of the evidence the existence of pneumoconiosis by x-ray evidence.

b. Biopsy Evidence

Pursuant to §718.202(a)(2) Claimant may establish pneumoconiosis through the use of biopsy evidence. Since no such evidence was submitted, it is clear that pneumoconiosis has not been established in this manner.

c. The Presumptions

Under §718.202(a)(3) it shall be presumed that a miner is suffering from pneumoconiosis if the presumptions provided in §§718.304, 718.305, or 718.306 apply.

Initially, I note that Claimant cannot qualify for the §718.305 presumption because he did not file this claim before January 1, 1982. Claimant is also ineligible for the §718.306 presumption because he is still living. Moreover Claimant is ineligible for the §718.304 presumption as there is no evidence that Claimant suffers from complicated pneumoconiosis.

Based on the foregoing, it is clear Claimant has failed to establish the existence of

pneumoconiosis pursuant to §718.202(a)(3).

d. Medical Opinions

Lastly, under §718.202(a)(4) a finding of pneumoconiosis may be based on the opinion of a physician, exercising sound medical judgment, who concludes that the miner suffers or suffered from pneumoconiosis. Such conclusion must be based on objective medical evidence and must be supported by a reasoned medical opinion. Of record are the opinions of Drs. Ahluwalia, Ryan, Pollock, Raymond Kraynak, Matthew Kraynak, and Galgon.

Dr. Ahluwalia, who is Board-Eligible in Internal Medicine, conducted an examination of behalf of the Department of Labor and submitted a report dated 9-14-95. DX-9. He reviewed Claimant's occupational history and noted a family medical history of high blood pressure, heart disease and stroke. Claimant's medical history was positive for arthritis in the left knee, heart attack and CABG in 1994, and diabetes since 1984. Claimant reported a negative smoking history. Claimant's chief complaints were sputum production, daily cough for one year, shortness of breath going up hill or up steps for two years, hemoptysis once in awhile, and chest pain one year ago with admission to hospital. Physical examination was unremarkable. Dr. Ahluwalia reviewed a vent study and arterial blood gas study performed on 9-14-95. Dr. Ahluwalia concluded Claimant had coronary artery disease, status post myocardial infarction, status post CABG; and diabetes mellitus. He added that Claimant had no impairment noted on objective pulmonary function testing.

Dr. Ahluwalia also appeared and testified at a hearing before Judge Teitler on May 9, 1997. DX-70. At that hearing, Dr. Ahluwalia reiterated the findings in his report and found a complete absence of pneumoconiosis and no pulmonary impairment. DX-70, TR 216.

Dr. Denzel Pollock submitted a medical note dated May 28, 1996. DX-47. Dr. Pollock is Board-Certified in Internal Medicine and Cardiovascular Disease. Dr. Pollock had been treating Claimant since July of 1994 when he was admitted with acute anterior MI. Claimant was ultimately transferred to Lehigh Valley Hospital where he underwent placement of four coronary artery bypass grafts on 8-1-94. Claimant had a rapid recovery with no signs of congestive heart failure or recurrent angina. He demonstrated no signs of ischemia as of 3-13-95 when a nuclear stress test was performed. Claimant was on aspirin only. As of Claimant's last visit on October 12, 1995, his cardiac standpoint was stable.

Dr. John Ryan conducted an examination on behalf of the Department of Labor and submitted a report dated July 1, 1996. DX-28. Dr. Ryan is Board-Certified in Internal Medicine and Pulmonary Disease. Dr. Ryan reviewed Claimant's coal mine employment. He noted a family medical history of high blood pressure, heart disease and stroke. He also noted an individual medical history of attacks of intermittent wheezing over the past

year, myocardial infarction in 1994, and diabetes mellitus since 1994. Dr. Ryan added that Claimant had open heart surgery with four bypasses in July of 1994. He had arthroscopic surgery on the left knee in 1989. Claimant's symptoms included daily sputum production for the past year, intermittent wheezing not related to weather or position for the past year, and intermittent cough throughout the day. Physical examination was unremarkable. Dr. Ryan reviewed a chest x-ray taken on 7-1-96 that was read as "normal." He also reviewed a vent study that showed moderate obstructive airways disease but noted that Claimant's effort could have been better in this effort dependent study. Arterial blood gases were also normal. Dr. Ryan concluded that Claimant had "possible bronchitis" but could not rule out underlying asthma. As to the etiology of the bronchitis, Dr. Ryan concluded there was no evidence of pneumoconiosis by x-ray or physical examination. Dr. Ryan stated that a suggested moderate obstructive impairment was seen on Claimant's PFTs, but recommended a repeat vent study to confirm. He added that if a repeat study was abnormal, Claimant should be referred to family physician to rule out asthma.

The medical report of Dr. Raymond Kraynak is dated August 19, 1996. DX-52. Dr. Kraynak is Board-Eligible in Family Medicine. DX-53. Dr. Kraynak noted he had been treating Claimant since 7-24-96. Claimant's symptoms included shortness of breath, productive cough, and exertional dyspnea. Claimant reported having difficulty walking one to two blocks or up one flight of steps without becoming short of breath. Dr. Kraynak noted Claimant had bypass surgery in July of 1994. Claimant was on Glynase, Ansaid, baby aspirin, and Proventil inhaler. Dr. Kraynak reviewed Claimant's occupational history and noted seven (7) years of coal mine employment. Dr. Kraynak reviewed a pulmonary function test from 7-24-96 that showed FEV-1 of 24%, FVC of 45% and an MVV of 28% of predicted. A chest x-ray of 9-14-95 was read by Dr. Smith, a Board-Certified B-reader, as type "p" pneumoconiosis, category 1. Physical examination revealed a patient older than stated age, lips were slightly cyanotic, there was a mild increase in the AP diameter and scattered wheezes were detected in all lung fields. Dr. Kraynak concluded based on Claimant's coal mine employment history of seven (7) years, complaints, physical examination, and diagnostic studies, that Claimant was totally and permanently disabled due to coal worker's pneumoconiosis. Claimant was unable to lift or carry, climb steps or walk for any period of time. He must be able to sit, stand, and lay down, at his leisure, secondary to his severe impairment.

Dr. Kraynak was deposed on August 16, 1996. At that time he reiterated the findings in his report. DX-55.

Dr. Matthew Kraynak submitted a medical report dated July 13, 1999. DX-81. Dr. Kraynak is Board-Certified in Family Medicine. He reported Claimant complained of shortness of breath and exertional dyspnea. Claimant reported becoming short of breath walking a distance of one half to one block or up several steps. He noted bypass surgery in 1994. Claimant was on Glynase, baby aspirin, and Proventil inhaler. Dr. Kraynak noted an

occupational history of five (5) years of coal mine employment. He reviewed a pulmonary function study from 6-17-99 that revealed an FEV-1 of 31%, FVC of 66% and an MVV of 51% of predicted. A chest x-ray from 9-14-95 was read by Dr. Smith as showing pneumoconiosis type "p," category 1. Physical examination revealed a patient older than stated age, lips were slightly cyanotic, there was a mild increase in the AP diameter and scattered wheezes were detected in all lung fields. Dr. Kraynak concluded based on Claimant's coal mine employment history of five (5) years, complaints, physical examination, and diagnostic studies, that Claimant was totally and permanently disabled due to coal worker's pneumoconiosis. Claimant was unable to lift or carry, climb steps or walk for any period of time. He must be able to sit, stand, and lay down, at his leisure, secondary to his severe impairment.

Dr. Raymond Kraynak was deposed for a second time on May 5, 2000. CX-8. He testified that he continued to treat Claimant every two months and was last seen on April 24, 2000. TR 5. He reiterated findings in his previous report. In response to the invalidation report of Dr. Ranavaya, Dr. Kraynak noted that the pulmonary function conducted on 6-17-99 by Dr. Matthew Kraynak was performed in accordance with criteria found in Appendix B of the 718 regulations. TR 8. He added that the pulmonary function study of 9-28-99 conformed to quality standards. He personally viewed the cooperation of Claimant and noted it was good. TR 9. He reviewed additional medical evidence and concluded Claimant was disabled due to CWP and that he would be unable to return to last coal mine employment or endure further exposure to coal dust. Dr. Kraynak noted Claimant was still employable in a light duty capacity "which he's still doing for the Ford Motor Company." TR 10. Dr. Kraynak opined that Claimant's cardiac condition was stable and that he had no disability from Diabetes or his cardiac condition. TR 11. He concluded Claimant's condition had worsened since his prior testimony. TR 11. There had been a gradual and progressive degradation of pulmonary capacity. TR 12. On cross-examination, Dr. Kraynak admitted the tracings of the vent study conducted on 7-17-99 did not show the inspiratory effort. Dr. Kraynak admitted he was not in the room with Claimant at the time of this study. TR 12. He noted Claimant sees a cardiologist once per year but did not know who that was nor did he ever speak to said doctor. TR 13.

Dr. John Galgon submitted a medical report dated July 21, 2000. DX-88. Dr. Galgon is Board-Certified in Internal Medicine, Pulmonary Disease, and Sleep Medicine. Claimant complained of shortness of breath for the last five years. He becomes short of breath when walking 200 feet on the level and also has to stop when walking up ten (10) steps. Claimant noted his breathing was "about the same now as it was 5 years ago." Claimant also reported an unchanged productive cough for the last five (5) years. Dr. Galgon reviewed Claimant's occupational history and medical history. Physical examination of the chest revealed good breath sounds without rales or wheezes. The remainder of the examination was unremarkable. A vent study performed at Lehigh Valley Hospital showed FVC of 95% of predicted. There was no evidence of obstructive airways disease with an FEV-1 of 107% of predicted. Following administration of a bronchodilator, no significant

improvement was noted. Dr. Galgon opined that any reduction in flows or volumes was most likely due to the patient tiring from the testing procedure. An arterial blood gas study was normal. An EKG performed on 7-12-00 showed evidence of old anteroseptal myocardial infarction. A chest x-ray taken on 5-4-00 showed evidence of vascular congestion. An x-ray taken on 7-13-00 was read as 0/1, q/p. Dr. Galgon concluded that Claimant did not have pneumoconiosis based on the chest x-ray that showed pneumoconiosis was not present; the vent study that showed no evidence of airways obstruction; and the arterial blood gases that were entirely normal. He added that Claimant clearly had heart disease. Moreover, Dr. Galgon noted Claimant had no impairment due to pulmonary disease. His impairment was secondary to his cardiac problem.

Out of the six (6) physicians who have rendered an opinion in this matter, Drs. Ahluwalia and Galgon concluded Claimant did not suffer from pneumoconiosis. Dr. Ryan concluded that there was no x-ray evidence of pneumoconiosis but noted "possible bronchitis" due to the results of a vent study that showed a moderate obstructive impairment with effort by Claimant "that could have been better." Dr. Ryan did not discuss the etiology of the obstructive impairment but suggested having the vent study repeated to verify the lower values. Whereas, Drs. Raymond Kraynak and Matthew Kraynak concluded Claimant did suffer from pneumoconiosis. Dr. Pollock, Claimant's cardiologist, did not render an opinion regarding the existence of pneumoconiosis therefore his opinion will be accorded less weight.

I find that since Dr. Ryan did not specifically discuss the etiology of Claimant's moderate obstructive impairment and "possible bronchitis", the possibility exists that Claimant could suffer from "legal pneumoconiosis." §718.201(a)(2). I find Dr. Ryan's opinion on this issue to be vague and entitled to less weight. *Griffith v. Director, OWCP*, 49 F.3d 184 (6th Cir. 1995).

I find the medical reports of Drs. Galgon and Ahluwalia are entitled to greater weight as they are well-reasoned and well-documented. *Fields v. island Creek Coal Co.*, 10 BLR 1-19 (1987); *Clark v. Karst-Robbins Coal Co.*, 12 BLR 1-149 (1989)(en banc). Their reports are based on valid objective medical testing which showed predominately normal values and are supported by the x-ray evidence and the unremarkable physical examinations of Claimant. (see discussion of pulmonary function studies and arterial blood gases, infra).

Moreover, the qualifications of Dr. Galgon are superior to that of the Drs. Kraynak. He is Board-Certified in Internal medicine, Pulmonary Disease and Sleep Medicine. Dr. Galgon's opinion his supported by the conclusions of Dr. Ahluwalia. Although Dr. Ahluwalia is not board-certified in any field, his qualifications are more impressive than the Drs. Kraynak. Since 1983, he has practiced exclusively in the area of pulmonary medicine. In 1984 he was appointed Director of the Cardiopulmonary Laboratory,

Respiratory Therapy Department and Arterial Blood Gas Laboratory at Good Samaritan Hospital. In 1986 he was made Medical Director of the Cardiopulmonary Laboratory and Pulmonary Rehabilitation Clinic at the American Rehabilitation Center.

On the other hand, Drs. Matthew and Raymond Kraynak are less qualified than Drs. Galgon and Ahluwalia. While Dr. Matthew Kraynak is Board-Certified in Family Medicine and Dr. Raymond Kraynak is Board-Eligible in Family Medicine, neither has an expertise in pulmonary medicine. Their reports are not well-reasoned and are based, in part, on invalidated vent studies (see discussion infra). Their abnormal findings on physical examination (i.e. cyanosis, wheezing) are not supported by any other physician and are contrary to every credible objective finding of record.

Although Drs. Kraynak appear to be Claimant's treating physicians since 7-24-96, there is no evidence as to what occurred during any of these visits, what examinations or treatment took place, what testing was or was not administered, or what information was obtained from these visits which would give these physicians superior knowledge to diagnose Claimant. Since the opinions of the Drs. Kraynak are not well-reasoned or supported by objective medical evidence, they are not accorded significant weight. *Lango v. Director, OWCP*, 104 F.3d 573 (3d Cir. 1997).

Based on the foregoing, I find Claimant has failed to establish the existence of pneumoconiosis pursuant to §718.202 (a)(4).

e. The Existence of Pneumoconiosis Pursuant to 20 C.F.R. 718.202(a)

I must now weigh all the relevant evidence under 718.202(a) in determining whether Claimant has established the existence of pneumoconiosis. *Penn Allegheny Coal Co. v. Williams*, 114 F.3d 22 (3d Cir. 1997).

As noted previously, I found that the preponderance of the evidence in the record does not establish the existence of pneumoconiosis pursuant to 718.202(a)(1) – (3). There were no autopsy or biopsy results in the record pursuant to 718.202(a)(2). In addition, none of the presumptions contained within 718.202(a)(3) were found to be applicable. Accordingly, the Claimant's chest x-rays pursuant to 718.202(a)(1) and the medical reports pursuant to 718.202(a)(4) are considered relevant evidence in making this determination.

After weighing the evidence, I find that Claimant failed to prove, by the preponderance of the evidence, the existence of pneumoconiosis pursuant to §718.202(a)(1) that allows for the establishment of pneumoconiosis by chest x-ray. He also failed to establish pneumoconiosis pursuant to §718.202(a)(4) that allows for the establishment of pneumoconiosis through the well-reasoned medical report of a physician.

I further find, in weighing all of the relevant evidence together, that Claimant failed to establish the existence of pneumoconiosis by a preponderance of the evidence pursuant to 718.202(a). The well-reasoned opinions of Drs. Ahluwalia and Galgon, supported by the credible objective evidence, outweigh the reports of Drs. Raymond Kraynak and Matthew Kraynak.[7] Therefore, the Claimant has failed to establish by the preponderance of the evidence that he suffers from pneumoconiosis pursuant to 718.202(a).

Cause of Pneumoconiosis Pursuant to 718.203

Once it is determined that the miner suffers from pneumoconiosis, it must be determined whether the miner's pneumoconiosis arose, at least in part, out of coal mine employment. 20 C.F.R. 718.203(a).

If Claimant had established the existence of pneumoconiosis and more than ten (10) years of coal mine employment, Director indicated in his closing brief that they would concede that Claimant would be entitled to the rebuttable presumption that pneumoconiosis was due to Claimant's coal dust exposure. However, since Claimant was unable to establish the existence of pneumoconiosis, this element is moot.

Total Disability Due to Pneumoconiosis Pursuant to 718.204(b)

The finding of the existence of a totally disabling respiratory or pulmonary impairment shall be made under the provisions of Section 718.204. In making this determination, I must evaluate all relevant evidence. *See Fields v. Island Creek Coal Co.*, 10 BLR 1-19 (1987). A claimant shall be considered totally disabled if he is prevented from performing his usual coal mine work or comparable and gainful work. In the absence of contrary probative evidence, evidence which meets one of the Section 718.204(c) standards shall establish claimant's total disability. *See Shedlock v. Bethlehem Mines Corp.*, 9 BLR 1-195 (1986).

According to §718.204(c), the criteria to be applied in determining total disability include: 1) pulmonary function studies, 2) arterial blood gas test, 3) a diagnosis of cor pulmonale with right-sided congestive heart failure, and 4) a reasoned medical opinion concluding total pulmonary or respiratory disability. I must also consider claimant's testimony in all of the hearings to compare the medical opinion disability assessments against that testimony regarding the physical requirements of his usual coal mine work. *See generally Onderko v. Director, OWCP*, 14 BLR 1-2 (1988). His testimony by itself is not sufficient to support a finding of total disability (20 C.F.R. 718.204(d)(2).

[7] see discussion above

Pulmonary Function Studies

In order to demonstrate total respiratory disability on the basis of pulmonary function study evidence, a claimant may provide studies, which, accounting for sex, age, and height, produce a qualifying value for the FEV 1 test, plus either a qualifying value for the FVC test, or the MVV test, or a value of the FEV 1 divided by the FVC less than or equal to 55 percent. "Qualifying values" for the FEV 1, FVC and the MVV test are measured results less than or equal to the values listed in the appropriate tables of Appendix B to 20 C.F.R. Part 718. *See Director, OWCP v. Siwiec*, 894 F.2d 635, 637 n.5, 13 BLR 2-259 (3d Cir. 1990).

Assessment of the pulmonary function study results is dependent on the Claimant's height, which has been recorded between 66 and 67 ¾ inches. Considering this discrepancy, I find that Claimant's height is 66.2 inches for purposes of evaluating the pulmonary function studies. *See Protopappas v. Director, OWCP*, 6 BLR 1-221 (1983).

The Secretary's regulations allow for the review of pulmonary function testing by experts who can review the ventilatory tracings and determine the validity of a particular test. 20 C.F.R. §718.103 and Part 718, Appendix B; *Siwiec*, *supra*; *see generally Ziegler Coal Co. v. Sieberg*, 839 F.2d 1280, 1283, 11 BLR 2-80 (7th Cir. 1988). Thus, in assessing the probative value of a clinical study, an administrative law judge must address "valid contentions" raised by consultants who review such tests. *See Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276, 18 BLR 2-42 (7th Cir. 1993); *Dotson v. Peabody Coal Co.*, 846 F.2d 1134, 1137-38 (7th Cir. 1988); *Strako v. Ziegler Coal Co.*, 3 BLR 1-136 (1981); *also see Siegel v. Director, OWCP*, 8 BLR 1-156 (1985)(2-1 opinion with Brown, J., dissenting); *accord Winchester v. Director, OWCP*, 9 BLR 1-177 (1986).

The Third Circuit has emphasized that the administrative law judge "must determine whether the tests meet the quality standards and whether the medical evidence is reliable[.]" *Siwiec*, 894 F.2d at 638, 13 BLR 2-259.

The record includes the following pulmonary function study evidence:

Ex. No.	**Date**	**Age**	**Ht.**	**FEV1**	**FVC**	**MVV**	**FEV1/FVC**	**Qualify**
DX-8	9-14-95	53	66"	2.73	3.33	53	82%	No

Dr. Ahluwalia interpreted this test as showing normal flows without any evidence of obstructive or restrictive lung disease. Claimant's cooperation was noted as fair and comprehension was good.

Dr. Raymond Kraynak invalidated this study because the tracings were not uniform, were inconsistent, and showed excessive variability.

I decline to credit Dr. Kraynak's invalidation, since Dr. Ahluwalia's study recorded "fair" cooperation. Moreover, I find Dr. Ahluwalia's credentials to be superior to those of Dr. Kraynak. Although Dr. Ahluwalia is not board-certified in any field, his qualifications are impressive. Since 1983, he has practiced exclusively in the area of pulmonary medicine. In 1984 he was appointed Director of the Cardiopulmonary Laboratory, Respiratory Therapy Department and Arterial Blood Gas Laboratory at Good Samaritan Hospital. In 1986 he was made Medical Director of the Cardiopulmonary Laboratory and Pulmonary Rehabilitation Clinic at the American Rehabilitation Center. Whereas, Dr. Kraynak is Board-Eligible in Family Medicine and has no particular expertise in pulmonary medicine. See *Martinez v. Clayton Coal Co.*, 10 BLR 1-24 (1987); *Dillon v. Peabody Coal Co.*, 11 BLR 1-113 (1988); *Wetzel v. Director, OWCP*, 8 BLR 1-139 (1985); *see generally Clark v. Karst-Robbins Coal Co.*, 12 BLR 1-149 (1989)(en banc).

Ex. No.	**Date**	**Age**	**Ht.**	**FEV1**	**FVC**	**MVV**	**FEV1/FVC**	**Qualify**
DX-29	7-1-96	54	66"	1.39	2.93	-----	47%	No

Dr. Ryan, who is Board-Certified in Internal Medicine and Pulmonary Disease, interpreted this test as showing moderate obstruction as well as possible concomitant restrictive defect. Dr. Ryan noted that Claimant's effort could have been better and suggested having a repeat study to confirm results.

Dr. Simelaro, who is Board-Certified in Internal and Pulmonary Medicine, as well as a medical school professor, validated this study as being done appropriately. He added that the values show a disabling lung disease. He noted that although the lungs may have a moderate obstructive impairment, the blood gases may be totally normal. DX-69.

Dr. Prince, who is Board-Certified in Internal Medicine, Pulmonary Disease, and Critical Care Medicine, checked a box on a form "vents are acceptable." CX-12.

I will credit the highly qualified opinion of Dr. Ryan who is Board-Certified in Pulmonary Medicine It is clear from Dr. Ryan's report that the results of the study were questionable due to the effort of Claimant and Dr. Simelaro does not address the issue of effort directly.

Although Dr. Prince is highly qualified, I attribute more weight to the opinion of Dr. Ryan who specifically identified a flaw in the study, i.e. Claimant's lack of effort, as opposed to Dr. Prince who merely validated the study by checking a box on a form. Without more explanation, I will not accord Dr. Prince's validation significant weight. In *Milburn Colliery Co. v. Hicks*, 138 F.3d 524, 21 BLR 2-269 (4th Cir. 1998), the Fourth Circuit ruled that a validation of an arterial blood gas study which consisted of a checked box "lent little additional persuasive authority" to that claimant's case. 138 F.3d at 530, 21 BLR 2-269.

Accordingly, I find this study to be unreliable.

Ex. No.	Date	Age	Ht.	FEV1	FVC	MVV	FEV1/FVC	Qualify
DX-51	7-24-96	54	66”	.74	1.86	33	40%	Yes

Dr. Raymond Kraynak interpreted this test as showing a severe restrictive defect. Claimant’s cooperation and comprehension were noted as “good.”

Dr. Ranavaya, who is Board-Certified in Occupational Medicine, invalidated this study because it did not meet the NIOSH/American Thoracic Society criteria for valid, reproducible spirometry. Moreover, Claimant’s effort, cooperation, and comprehension were less than optimal. DX-25.

Dr. Raymond Kraynak, who is Board-Eligible in Family Medicine, responded to the invalidation by Dr. Ranavaya and stated the vent study was valid. He noted that the only standard to be used to determine the validity of pulmonary function studies is the 718 Regulations. He maintained that this study met those requirements. Dr. Kraynak also pointed out that Dr. Ranavaya failed to say why the study did not meet the NIOSH/American Thoracic Society criteria. DX-56.

Dr. Ranavaya’s credentials are impressive. He has in addition to his medical degree, a Masters of Science in Occupational Health and Safety and was engaged in a research project on disability/impairment among coal miners with occupational lung disease. He is Board-Certified by the American Board of Independent Medical Examiners and is a NIOSH Certified “B” reader. Dr. Ranavaya also possesses a NIOSH Certificate in Spirometry and has significant teaching experience and has published articles related to occupational disease. Dr. Kraynak is not Board-Certified in any area. I credit Dr. Ranavaya’ medical opinion based on his superior qualifications and accordingly, I find this study invalid and unreliable. *See Martinez, Dillon, Wetzel and Clark, supra.*

Ex. No.	Date	Age	Ht.	FEV1	FVC	MVV	FEV1/FVC	Qualify
DX-54	8-23-96	54	$67_{3/4}$	1.31	1.46	14	90%	Yes

This test was performed at the William H. Ressler Center. Dr. Kraynak interpreted the results as showing a severe restrictive defect. Claimant’s cooperation was noted as “fair” and comprehension was noted as “good.”

Dr. Michos, who is Board-Certified in Internal Medicine and at that time only Board-Eligible in Pulmonary Disease, invalidated this study because exhalation was not maintained for a minimum of five (5) seconds or until a plateau in the volume time curve had elapsed. He also suspected incomplete exhalation and breath holding. He recommended a repeat vent study with flow volume loops. DX-35.

Dr. Raymond Kraynak responded to the invalidation by noting that the study was valid. He noted that exhalation extended for at least six (6) seconds and ended with the plateau. The MVV tracings continued for twelve (12) seconds and varied by no more than 10% that corresponded to a good effort. DX-62.

Based on his superior credentials, I credit the opinion of Dr. Michos over the opinion of Dr. Kraynak. *See Martinez, Dillon, Wetzel and Clark, supra.* Moreover, the report of Dr. Michos corroborated the comments of the technician at the William Ressler Center that noted only fair cooperation by Claimant.

Ex. No.	**Date**	**Age**	**Ht.**	**FEV1**	**FVC**	**MVV**	**FEV1/FVC**	**Qualify**
DX-79	6-17-99	57	66”	.93	2.72	59	34%	Yes

Dr. Matthew Kraynak interpreted this test as showing a severe restrictive defect. Claimant’s cooperation and comprehension were noted as “good.”

Dr. Ranavaya invalidated this vent study because it did not meet the NIOSH/American Thoracic Society criteria for valid, reproducible spirometry. Moreover, Claimant’s effort, cooperation, and comprehension, were less than optimal. DX-79.

Dr. Matthew Kraynak disagreed with the invalidation by Dr. Ranavaya. He maintained the study was valid and that it complied with the criteria set forth in 718 of the Regulations. CX-1.

Dr. Raymond Kraynak also disagreed with the invalidation by Dr. Ranavaya. He stated that the study was in accordance with criteria found in Appendix B, 718 Regulations. CX-8. Dr. Kraynak admitted he was not present at the time the test was administered and that the tracings did not show the inspiratory effort. CX-8. Dr. Kraynak fails to demonstrate that the NIOSH/ATS criterion are materially different.

I have carefully considered the rebuttal opinions of Dr. Matthew Kraynak and Dr. Raymond Kraynak. However, I find this test unreliable in view of Dr. Ranavaya’s review. I credit this consultant on the basis of his superior qualifications. *See Martinez, Dillon, Wetzel and Clark, supra.*

Ex. No.	**Date**	**Age**	**Ht.**	**FEV1**	**FVC**	**MVV**	**FEV1/FVC**	**Qualify**
CX-2	9-28-99	57	66”	.58	1.81	37	32%	Yes

Dr. Raymond Kraynak interpreted this test as showing a severe restrictive defect. Claimant’s cooperation and comprehension were noted as “good.”

Dr. Prince checked a box on a form “vents are acceptable.” CX-3.

Dr. Cander, who is Board-Certified in Internal Medicine and Board-Eligible in Pulmonary Disease, invalidated this study because of the variability of the FEV-1 and FVC was significantly above the 5% required of spirometric studies by the 718 Regulations. Lack of effort was shown by bumps along the course of the curve, as shown on all three curves; an essentially straight line over the first 75% of the FVC, as noted in the two largest curves; and the fact that none of the tracings reached a plateau, documenting failure to achieve complete expiration. DX-86.

Dr. Raymond Kraynak disagreed with the invalidation by Dr. Cander. He noted that the variability of the tracings was less than 85 ml, corresponding to the Regulations. The tracings were very uniform and consistent and reached a good plateau, showing good effort. He maintained the study was valid. CX-16.

Dr. Matthew Kraynak also disagreed with Dr. Cander's invalidation of this study. He noted that the variability of the two largest FEV-1s was less than 25 ml, corresponding to the Regulations. They showed consistent effort. He did not detect any bumps on the tracings or an essentially straight line over the first 75% of the FVC or the lack of a plateau. The MVV showed severe disability. He maintained the study was valid. CX-17.

I have carefully considered the rebuttal opinions of Dr. Matthew Kraynak and Dr. Raymond Kraynak. However, I find this test unreliable in view of Dr. Cander's review. I credit this consultant on the basis of his superior qualifications. *See Martinez, Dillon, Wetzel and Clark, supra.*

Although Dr. Prince is highly qualified, I attribute more weight to the opinion of Dr. Cander who specifically identified flaws in the study as opposed to Dr. Prince who merely validated the study by checking a box on a form. Without more explanation, I will not accord Dr. Prince's validation significant weight. See *Milburn supra.* Accordingly, I find this study to be unreliable.

Ex. No.	**Date**	**Age**	**Ht.**	**FEV1**	**FVC**	**MVV**	**FEV1/FVC**	**Qualify**
CX-15	6-1-00	58	66"	1.47	2.25	50	65%	Yes

Dr. Raymond Kraynak interpreted this study as showing a severe restrictive defect. Claimant's comprehension and cooperation were noted as "good."

Dr. Cander invalidated this study because all of the tracings revealed bumps that indicated failure to maintain maximum expiratory flow. Further, the FVC result was only 58% of the result obtained on the 7-13-00 study and the FEV-1 on this study was only 47% of the value obtained on the 7-13-00 study. The only explanation can be that this study did not represent the maximum respiratory effort. DX-87.

I find this test invalid on the basis of Dr. Cander's qualifications. *See Martinez, Dillon, Wetzel, supra.*

Ex. No.	Date	Age	Ht.	FEV1	FVC	MVV	FEV1/FVC	Qualify
DX-88	7-13-00	58	66"	3.16	3.88	77	81%	No

Dr. Galgon interpreted this study as being normal. Claimant's cooperation and comprehension were noted as "good."

I find this study to be in substantial compliance with the Regulations.

Discussion

Upon reviewing the pulmonary function study evidence of record, I find that Claimant has not demonstrated total respiratory disability at §718.204(c)(1) by a preponderance of the pulmonary function study evidence in the record as a whole.

Out of the eight (8) pulmonary function studies in the record, I find the studies performed on 9-14-95 (DX-8) and 7-13-00 (DX-88) to be valid, conforming, and in substantial compliance with the regulations. Both of the foregoing tests produced non-qualifying values. As discussed above, I find that the remaining studies have been invalidated by the well-reasoned opinions of highly qualified consultants. All of these invalidated, non-conforming studies, performed by or at the request of either Dr. Raymond Kraynak or Dr. Matthew Kraynak, consistently produced substantially lower values than those tests that were found to be conforming. When a conforming vent study yields values higher than those found in another invalidated study, the conforming study, given that these studies are effort dependent, is obviously more reliable than the study with lower values. Indeed the Third Circuit has held that pulmonary function testing is effort-dependent and spurious low values can result, but spurious high values are not possible. *Andruscavage v. Director, OWCP*, No. 93-3291 (3rd Cir. February 22, 1994)(unpublished slip op. At 9-10). The Third Circuit reasoned that "[m]edical literature supports the …conclusion that [pulmonary function studies] which return disparately higher values tend to be more reliable indicators of an individual's respiratory capacity than those with lower values." *Id* at 10.

A wide disparity in values returned by different tests warrants the ALJ's decision to credit the results of the last, normal study over those with lower values that preceded it. *Baker v. North American Coal Corp.*, 7 BLR 1-79, 1-80 (1984).

Therefore, I find the conforming studies 9-14-95 (DX-8) and 7-13-00 (DX-88) both of which were non-qualifying, to be more probative than those performed by Drs. Kraynak.

Moreover, I find that the most recent pulmonary function study, which was administered by

Dr. Galgon on July 13, 2000, is entitled to considerable weight. I consider it significant in that the values obtained by Dr. Galgon in this effort dependent test were once again significantly higher than those obtained by Drs. Kraynak. In fact, all of the studies performed by other physicians in the record produced results that were consistently higher than those obtained by Drs. Matthew and Raymond Kraynak. For these reasons, I therefore find that Claimant has failed to demonstrate total respiratory disability on the basis of the pulmonary function study evidence.

Arterial Blood Gas Studies

A claimant may demonstrate total disability with arterial blood gas tests which, accounting for altitude, demonstrate qualifying results as specified in Appendix C to 20 C.F.R. Part 718. 20 C.F.R. §718.204(c)(2).

The current record contains the following blood gas studies:

Ex. No.	Date	Alt.	PCO2	pO2	Qual.
DX-10	9-14-95	0-2999	41	85	No
			*34	*95	No
DX-30	7-1-96	0-2999	39	84	No
DX-88	7-13-00	0-2999	42	90	No

*post-exercise

None of the arterial blood gas test results demonstrate total respiratory disability at Section 718.204(c)(2). I therefore find that Claimant has failed to demonstrate total respiratory disability on the basis of the blood gas study evidence.

Cor pulmonale

A claimant may demonstrate total disability with medical evidence of cor pulmonale with right-sided congestive heart failure in addition to pneumoconiosis.
Because there is no evidence of cor pulmonale with right-sided congestive heart failure, I am unable to find that Claimant has demonstrated total disability at Section 718.204(c)(3). 20 C.F.R. §718.204(c)(3); *see Newell v. Freeman United Coal Mining Co.*, 13 BLR 1-37 (1989), *rev'd on other grounds*, 933 F.2d 510, 15 BLR 2-124 (7th Cir. 1991).

Medical Opinion Evidence

Claimant may demonstrate total respiratory disability by a reasoned medical opinion that

assesses total respiratory disability, if the opinion is based on medically acceptable clinical and laboratory diagnostic techniques. Claimant must prove his respiratory or pulmonary condition prevents him from engaging in his "usual coal mine employment or comparable and gainful employment." 20 C.F.R. §718.204(c)(4). Any loss in lung function may qualify as a total respiratory disability under Section 718.204(c). *See Carson*, 19 BLR at 1-21, *modified on recon.* 20 BLR 1-64 (1996).

There are six (6) physicians who have rendered an opinion in this case. Dr. Pollock, Claimant's cardiologist, did not render an opinion regarding the issue of total disability and therefore his opinion will be accorded less weight. Drs. Raymond Kraynak and Matthew Kraynak opined Claimant suffered from a permanent, total respiratory disability that would prevent Claimant from engaging in his last mine employment. Drs. Ahluwalia and Galgon opined Claimant maintained the respiratory capacity to perform his last coal mine employment.

Dr. Ryan indicated there was a "suggested moderate obstructive impairment….but before this is confirmed would recommend repeating the spirogram again." He did not indicate whether this suggested impairment would prohibit Claimant from performing his last coal mine employment. Accordingly, I will accord less weight to the opinion of Dr. Ryan on this issue.

Upon review of the medical opinion evidence as a whole, I find that Claimant has not met his burden of proving total pulmonary or respiratory disability at Section 718.204(c)(4). I am mindful of Dr. Raymond Kraynak and Dr. Matthew Kraynak's status as treating physicians. I nevertheless credit Dr. Galgon's most recent medical opinion, that Claimant is not totally disabled, on the basis of his credentials, the thoroughness of his report, and the clinical testing which forms some of the documentation in support of his conclusions. *See Sterling Smokeless Coal Co. v. Akers*, 131 F.3d 438, 441, 21 BLR 2-269 (4th Cir. 1997); *Clark v. Karst-Robbins Coal Co.*, 12 BLR 1-149 (1989)(en banc); *Dillon v. Peabody Coal Co.*, 11 BLR 1-113 (1988). Moreover, Dr. Galgon's conclusions are supported by the detailed report of Dr. Ahluwalia.

I accord less weight to the reports of Drs. Raymond and Matthew Kraynak. They report physical findings, such as cyanotic lips and wheezing, that are not consistent with physical findings reported by other physicians of record. Their conclusions of disability are based, at least in part, on invalidated pulmonary function studies that consistently yield lower results than those produced in other studies. For these reasons, I accord less weight to the foregoing opinions.

Reviewing the detailed findings and conclusions of Drs. Galgon and Ahluwalia including the extensive use of pulmonary function and arterial blood gas tests, I find that their opinions sufficiently undermine Claimant's case so that the medical opinion evidence does not persuasively demonstrate total respiratory disability at Section 718.204(c)(4).

Total Respiratory Disability

After evaluating like-kind evidence under each provision of section 718.204(c), I must then evaluate all relevant evidence at Section 718.202(c), like and unlike, to find whether Claimant has established total respiratory disability. *See Fields v. Island Creek Coal Co.*, 10 BLR 1-19 (1987). Upon my consideration of all relevant evidence, like and unlike, including Claimant's testimony, see generally *Onderko v. Director, OWCP*, 14 BLR 1-2, 1-4 (1988); see also *Poole v. Freeman United Coal Mining Co.*, 897 F.2d 888, 894, 13 BLR 2-348 (7th Cir. 1990), I conclude that Claimant has not met his burden of establishing total disability.

I find that the non-qualifying arterial blood gas studies, the credible non-qualifying pulmonary function studies, the most recent report from Dr. Galgon, which is detailed, comprehensive and corroborated by the earlier report from Dr. Ahluwalia constitute "contrary probative evidence" which precludes a finding of total disability pursuant to Section 718.204(c). Again, I have accounted for multiple opinions from Claimant's treating physicians. Nevertheless, I find, in the face of contrary probative evidence, that Claimant has failed to prove total respiratory disability by a preponderance of the evidence. Although Claimant need only establish total disability by a preponderance of the evidence, "the preponderance standard is not toothless." *See United States v. Roman*, 121 F.3d 136, 141 (3d Cir. 1997), *cert. denied* 522 U.S. 1061 (1998).

Modification

I find, after a de novo review of the record as a whole, that Claimant has not proven that the prior determination, that he is not entitled to benefits, is mistaken. In the alternative, I also conclude, upon review of this evidence, especially the most recent medical reports and studies, that reopening this claim on the basis of the evidence filed in support of his request for modification would render justice under the Act. *See generally Hampton v. Cumberland Mountain Services Corp.*, BRB No. 99-0186 BLA (May 31, 2000)(unpub.) I am not persuaded that the extant record as a whole adequately supports the conclusion that Claimant's condition is worsening so that an evolution in his condition militates against finality in this instance. I further conclude Claimant has failed to establish a change in conditions.

I hasten to emphasize that Claimant is not being penalized for filing requests for modification. I find, as a matter of fact, that Claimant's pursuit of modification is in good faith. *See generally, Keating*. Indeed, pneumoconiosis is a progressive disease, and, as has been pointed out by the Fourth Circuit, " the health of a human being is not susceptible to once-in-a-lifetime adjudication." *Stanley*, 194 F.3d at 500 n.4, 22 BLR 2-1.

Disability Causation

The final issue is whether Claimant has established disability causation at Section 718.204(b). Claimant bears the burden of proving that pneumoconiosis is a substantial contributor to Claimant's total respiratory disability. *Bonessa v. U.S. Steel Corp.*, 884 F.2d 726, 13 BLR 2-23 (3d Cir. 1989). In this case the record does not establish the existence of a totally disabling respiratory or pulmonary impairment. Assuming that Claimant had established total disability, I find that he has not convincingly established that pneumoconiosis is a substantial contributor to this total disability. Again, I credit the opinion of Dr. Galgon that Claimant suffers from no pulmonary or respiratory impairment, on the basis of his superior credentials in the field of Internal Medicine and Pulmonary Disease.

Conclusion

Because Claimant has failed to prove any element of entitlement, I must conclude that he has failed to establish entitlement to benefits under the Act.

Order

The claim of Joseph S. Bridi for benefits under the Act is hereby DENIED.

A
Ainsworth H. Brown
Administrative Law Judge

Attorney Fees

The award of an attorney's fee under the Act is permitted only in cases in which Claimant is found to be entitled to benefits. Since benefits are not awarded in this case, the Act prohibits the charging of any fee for services rendered to him in pursuit of this claim.

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. §725.481, any party dissatisfied with this Order may appeal it to the Benefits Review Board within 30 days from the date of this decision, by filing a Notice of Appeals with the Benefits Review Board, P.O. Box 37601, Washington, D.C. 20013-7601. A copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits. His address is Room N-2117, Frances Perkins Building, 200 Constitution Avenue, N.W., Washington, D.C. 20210.